Alternatives to Detention: Immigration Reform Grounded in Public Health

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See also Ly et al., p. 1497.

In this issue of *AJPH*, Ly et al. (p. 1497) outline arguments for ending immigrant detention in the United States and propose both rights-based and health-based rationale for why the United States should move to alternatives to detention. They detail various international treaties, some US-ratified and some not, that in totality secure the rights of people, including noncitizens, to physical and mental health and related protections. Given these and other legal instruments, Ly et al. systematically outline how US policy on immigrant detention violates detainees' human rights. Specifically, detention makes it impossible to realize detainees' right to health and, thus, endangers the greater public health.

Critically, Ly et al. also detail how the conditions within US immigrant detention centers, including overcrowding and lack of personal hygiene products, actively harm detainees by increasing their risk for communicable disease, which has been documented in numerous studies.[1,2] Such is the case during the COVID-19 pandemic in which some of the largest outbreaks have occurred in immigrant detention centers. The inability of detainees to physically distance, a key recommendation for decreasing COVID-19 spread, underscores how detention itself creates the greatest harm to detainees and actively prohibits their right to health.[3] Thus, Ly et al. argue for the urgent need for alternatives to administrative detention (ATDs).

As described by the authors, ATDs are practices through which asylum seekers and other relief-seeking migrants can be supported in the community setting while they await immigration proceedings. The most successful ATDs are those with robust social services including legal counsel, migrant rights–based counseling, and access to medical care, much as refugees are welcomed and supported when they arrive in the United States. It is worth noting that asylum seekers and refugees are seeking the same thing: relief from "persecution or fear of persecution due to race, religion, nationality, political opinion, or membership in a particular social group."[4] A refugee has been granted that status before arrival in the United States, whereas an asylum-seeker undergoes evaluation for relief after arrival to the United States. Notably, many more asylum seekers apply for relief than are eligible or are granted it, but the types of persecution from which refugees and asylum seekers flee are the same. Moving toward the model of welcome and support that refugees receive would have the multipronged benefit of allowing safer passage and entry to people who have both international and domestic rights to apply for asylum and also protect the general US public health by knowing more about those who enter the country.

The United States has attempted to pilot many ATD programs. One pilot program the authors describe is the Family Case Management Program (FCMP) run by Immigration and Customs Enforcement (ICE). FCMP was cut substantially short by the Trump administration, citing excessive cost. These changes were despite the Department of Homeland Security's own budgetary analysis in 2019 that demonstrated that US taxpayers paid $133.99 per day to detain an adult and $319.37 per day to detain a family in immigration detention, whereas the costs of an ATD program would be $4.13 per day for an adult and $36 per day for a family.[5,6] Official reports of the FCMP showed compliance rates of 99% with court appearances.[6] However, the FCMP was run by private contractors, which receive far more federal funding to operate detention centers than they do to run ATD programs.[5] According to public filings by one private contractor, ICE accounted for 25% or more of the total revenues earned from 2017 to 2019, representing nearly $1.5 billion paid for immigration

detention programs.[7] Thus, the lack of commitment to ATDs may not be driven by high costs but, rather, by financial rewards that incentivize detention over ATDs in the private sector. Future ATD programs in the United States may be most effective when run by local community service providers that seek to provide wrap-around services that include case management, legal counsel, and affordable housing, rather than by for-profit companies.

Moreover, as Ly et al. note, examples of ATDs can be found globally including in Costa Rica, Ecuador, and Sweden. These countries have ATDs specifically for asylum-seeking children and unaccompanied minors. Importantly, some ATDs, like those in South Korea, have been particularly useful during the COVID-19 pandemic as they have served as a way to test and treat more than 390 000 undocumented immigrants without arrests, thereby helping curb disease spread in this population and within their broader communities.

Presently, Ly et al. are completing a comparative analysis of migration laws and policies around the world, including use of detention and provision of ATDs. Their findings have the potential to greatly improve understanding of global best practices for rights-respecting immigration policies. However, to maximize the comprehensiveness and utility of their study, there must be inclusion of rigorous analysis of how these laws are implemented and enforced. For example, the Flores Settlement Agreement requires children in the United States to be detained for fewer than 72 hours by the Department of Homeland Security (i.e., Customs and Border Patrol and ICE) before either release or transfer to the custody of the Office of Refugee Resettlement.[8] Yet, as shown under multiple administrations at varying points in time, this rule is violated frequently.[9] While law and policy provide theoretical defenses, it is their implementation and enforcement that result in either protection or violation of detainees' rights.

Civil immigration detainees who have not been convicted of a crime also have legal protections under the US Constitution and case law. Under the Due Process Clause of the Fifth Amendment, federal detainees who have not been convicted cannot be held in conditions that amount to punishment.[10] Detention facilities are required to provide medical care based on standards set by the US Secretary of Health and Human Services and ICE detention standards. Facilities are also required to provide access to legal support (e.g., law library, attorney visits, legal mail, immigration hearings), recreation, family contact and visitation, and the opportunity to practice religious beliefs.[11] While scholars and advocates often lean on international treaties on human rights to demand legal security for detainees' rights, litigation in the United States has historically been necessary to demonstrate when these rights are not upheld. Thus, collaboration with litigators will be integral to establishing an immigration system grounded in public health.

For these reasons, we must heed Ly et al.'s recommendations to end immigrant detention and embrace ATDs while also implementing a multipronged approach that utilizes the rights-based arguments to create systems of implementation and accountability that ensure detained migrants' rights are upheld. Collaboration among governmental agencies including the Department of Health and Human Services, human rights lawyers, and medical and public health practitioners will be needed to create accountability measures. Furthermore, investments in partnerships with community-based organizations will strengthen the development of ATDs and move away from current for-profit management of detention alternatives. Lastly, with the aid of the findings from Ly et al.'s aforementioned global comparative analysis, improvements in current ATD models as well as domestic law to uphold their reliability will help ensure divestment from the current detention system. AJPH

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CONFLICTS OF INTEREST

R. Mishori is the senior medical advisor for Physicians for Human Rights. K. R. Peeler is a pro bono medical expert with Physicians for Human Rights.

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